## APPLICATION FOR INFORMAL HEARING

## COMPLETE AND RETURN TO

NEW JERSEY DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT DIVISION OF WORKERS' COMPENSATION PO BOX 381 TRENTON, NEW JERSEY 08625-0381

DEDACE DOINT

<u>PLEASE PRINT</u> <u>OR TYPE</u>					Social Security No.		
					(Mt	ist be 9 Digit	s)
Employee		Phone No.			Birth Date		
Address		City		Zip Code	(	County	
Employer				· · · • ·			
Address	_	City		Zip Code	(	County	
Insurance Company				Date of Accident			
Address		City			Zip Code		
Type of Injury	,			lersey 07102 ED STAMPED EN	VVELOPE)		
Hearing Requested by:	0000	Employee Employer Insurance Carrier Petitioners Attorney					
DID YOU BECOME EL	IGIBL HAT M	MEDICAID BENEFITS AT LE FOR MEDICAID BENE MEDICAID PAYMENTS RE	FITS AFTER TH	IE ACCIDENT?	YES	☐ NO	RDANCE
IMPORTAN	1	his proceeding will no TO FILE A FORMAL I ast payment and/or a carrier can bar any ac	PETITION with authorized m	thin two year edical treatm	s of the dat ent by the e	e of accide	nt or the
PLEAS	SE C	TO INSURE IM OMPLETE THIS FO			•	JRNED	
			Signature			Date	<u></u>

The Privacy Act, 5 U.S.C. § 552a, the Social Security Act, 42 U.S.C. § 405, and N.J.S.A. 34:15-1 et seq. authorize the Division of Workers' Compensation to request that the Petitioner supply the Division with his or her Social Security number for record keeping purposes and cross-matches with the Social Security Administration, Workforce New Jersey, Temporary Disability Insurance and any other proper public purpose.